AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Zepbound

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____

3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____

Mailing address: _____ City: _____ State: _____ ZIP: _____

7. Requester Contact Information: _____

Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity per 30 days: _____

11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days __Other:_____

Clinical Information

Initial Request: Zepbound for Obstructive Sleep Apnea

1. Are medical records attached ? Yes___ No___ ***Medical records are required for Obstructive Sleep Apnea prior authorization review.***
2. Is the beneficiary 18 years old or older? Yes____ No _____
3. Does the beneficiary have moderate to severe obstructive sleep apnea (OSA) with obesity? Yes___ No___
4. Does the beneficiary have a documented baseline BMI of $\geq$ 40kg/m^2 prior to beginning therapy? Yes___ No___

   BMI_____ **Date**_____
5. Is Zepbound prescribed in accordance with the FDA approved indications, age, weight (if applicable) and not exceed dosing limits per the prescribing Information per the clinical conditions for use? Yes___ No___
6. Is the beneficiary currently on and will continue lifestyle modification including structured nutrition and physical activity, unless physical activity is not clinically appropriate at the time GLP1 therapy commences? Yes___ No___
7. Will the beneficiary be using the requested agent in combination with another GLP-1 receptor agonist agent? Yes___ No___
8. Does the beneficiary have any FDA-labeled contraindications to the requested agent, including pregnancy, lactation, history of medullary thyroid cancer or multiple endocrine neoplasia type II? Yes___ No___
9. Is documentation attached to this request confirming that sleep apnea testing was performed, and sleep apnea was diagnosed? Yes___ No___
10. Has the beneficiary been instructed on sleep hygiene modifications before beginning Zepbound (for example, sleep positioning to avoid a non-supine position, avoidance of alcohol and stimulants before bed)? Yes___ No___

Continuation Request: Zepbound for Obstructive Sleep Apnea

1. Are medical records attached ? Yes___ No___ ***Medical records are required for Obstructive Sleep Apnea prior authorization review.***
2. Has the beneficiary been previously approved for the requested agent through Medicaid's Prior Authorization process for the covered indications that went into effect 10/01/2025? Note: beneficiaries not previously approved for the requested agent will require initial evaluation review]? Yes___ No___
3. Has medical documentation that beneficiary has improved while on the medication been included with this request? Yes___ No___
4. Are Individual clinical goals set by the provider being met? Yes___ No___
5. Is the beneficiary continuing to make adequate progress towards treatment goals? Yes___ No___
6. Is the beneficiary currently on and will continue lifestyle modification including structured nutrition and physical activity unless physical activity is not clinically appropriate? Yes___ No___
7. Will the beneficiary be using the requested agent with another GLP-1? Yes___ No___
8. Does the beneficiary have any FDA-labeled contraindications to the requested agent?? Yes___ No___
9. Has the provider performed a review of the beneficiary's medication list for possible dose reductions or discontinuation of medications for comorbid conditions, which are no longer needed or able to be reduced due to clinical effects of the medication? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406